MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

63-015899

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB — AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2270 STATE FILE NUMBER

FILED APR 29 1963

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — ITEM NO. — SHOULD READ — INSTEAD OF — DATE AMENDED — BY AFFIDAVIT OF — DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 18 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Kansas city
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1020 E 8
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First BYRL Middle ANDERSON Last
4. DATE OF DEATH Month 4 Day 14 Year 1963
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH 11-27-1916
9. AGE (last birthday) 46
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HR Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Murabile Mo
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Albert Anderson
13b. MOTHER'S MAIDEN NAME Ida Stinson
14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of servi
16. SOCIAL SECURITY NO.
17. INFORMANT Ida Anderson Address Cameron, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from —, to — and last saw her/him alive on —
Death occurred at — m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Geo. C. Kealhofer MD Deputy Coroner
22b. ADDRESS 667 Prospect Kans
22c. DATE SIGNED 4-15-63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4-16-1963
23c. NAME OF CEMETERY OR CREMATORY Murabile Cem.
23d. LOCATION (City, town; or county) (State) Murabile, Mo

24. FUNERAL DIRECTOR Noland Funeral Home ADDRESS Cameron, Mo
25. DATE RECD. BY LOCAL REG. 4-16-63
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

JUL 16 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed H C Sargentus

Licensed Embalmer No. 4554

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.